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ABSTRACT

During the spring and summer of 1975, 666 Mexican Americans in 3 Southern California cities were surveyed to examine the relationship between various social, economic, and cultural aspects of the Mexican American population and their contact with mental health services. Sixty-three of the respondents were considered to have had contact with mental health services. There was considerable cultural variation within the sample: 40% were first generation (born in Mexico); 35% were second generation (U.S. born with one or both parents born in Mexico); 19% were third generation (U.S. born with both parents born in the U.S.); 42% spoke mainly Spanish; 27% were bilingual; and 31% spoke primarily English. Factors examined included the belief in folk curing, socioeconomic status, marital status, female-headed household, language usage, level of acculturation, attitudes toward mental health services, and sources of emotional support. Findings indicated that those respondents who had contacted clinics and those who did not were equally likely to be of low socioeconomic status, have a fairly strong local extended family, and express little belief in or use of folk healers. Both relied on most non-professional sources of emotional support to the same extent and had generally favorable attitudes toward mental health services. Respondents who contacted clinics were more likely to be English speakers and single/separated/divorced/widowed, living in a female-headed household. Those who contacted clinics tended to consult often with friends and relatives. (NQ)

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MENTAL HEALTH AND CULTURAL CONTEXT: IMPLICATIONS FOR USE OF MENTAL HEALTH CLINICS BY MEXICAN AMERICANS

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Central to much of the recent research on mental health and Mexican Americans is the question, "Why do Mexican Americans underutilize public mental health services?" Underutilization has been established by several studies done in the Southwestern United States (Jaco, 1960; Karno and Edgerton, 1969; Keefe, Padilla and Carlos, in press; Torrey, 1972). Reasons suggested to account for this underutilization are numerous and include various social, economic, and cultural aspects of the Mexican American population as well as certain attributes of mental health clinics and the services they provide. Survey data is presented in this paper examining the relationship between these factors and contact with mental health services by Mexican Americans.

I. Reasons for Underutilization

Researchers have established that blue collar workers and other members of the lower socio-economic class underutilize health services in general including mental health cilnics in particular (Glasser, Duggan, and Hoffman, 1975; Rosenblatt and Suchman, 1964). It is reasonable to assume that SES variables, therefore, have much to do with utilization rates by Mexican Americans, who are predominantly lower class, blue collarites. McLemore (1963) has demonstrated that Mexican Americans' attitudes toward hospitalization are directly associated with level of education suggesting that SES factors are more important than ethnic differences in explaining why Mexican Americans may be more reluctant to use hospitals than Anglo Americans. A somewhat different perspective is taken by Nall and Speilberg (1967) who argue that social integration into the ethnic sub-community is primarily responsible for Mexican Americans' rejection of modern medical treatment. Thus, it is the combination of low SES and the socio-cultural adaptation to

economic scarcity (i.e. reliance on the collective support of family and community) which affect health behavior. The authors go on to suggest that this system operates among disadvantaged ethnic minority groups in general and is not peculiarly Mexican American.

Reliance on alternative resources, other than professional psychiatric care, appears to be a pan-cultural and -class method of seeking help for emotional problems (McKinlay, 1972; Keefe, Padilla and Carlos, in press; Torrey, 1972). Differences in degree of reliance on alternative sources of help, however, are far from clear. Madsen (1969) and Jaco (1957, 1960) contend that Mexican Americans are more likely than Anglos to rely on the extended family for emotional support, which consequently reduces their use of psychiatric services.[1] More recent data indicate little difference between Anglo Americans' and Mexican Americans' tendency to consult with relatives about emotional problems but ethnic differences are apparent in reliance on friends (Keefe, Padilla and Carlos, 1977). While Anglos and Mexican Americans both rely frequently on relatives, Anglos are more likely than Mexican Americans to turn to friends as well. This reluctance of Mexican Americans to expose their personal problems to non-family members has been observed in other studies (Madsen, 1964; Rubel, 1966). Other researchers cite Mexican Americans' reliance on doctors (Karno and Edgerton, 1969), ethnic community workers (Grebler, Moore, and Guzman, 1970; Moll, Rueda, Reza, Herrera, and Vasquez, 1976; Torrey, 1972), and folk healers (Creson, McKinley and Evans, 1969; Madsen, 1964; Kiev, 1968; Torrey, 1972) as reasons for their lower rate of mental health clinic use. Evidence presented by Keefe et al. (1977) indicates that both Anglos and Mexican Americans rely on doctors and clergymen with no clear relationship between rate of use and ethnicity. In addition, this study shows that Mexican Americans' use of ethnic community workers and

folk healers is so limited, neither can be of much importance in accounting for lower mental health clinic utilization.

Several researchers mention aspects of the mental health clinics themselves which discourage potential Mexican American clients, including geographic location of the clinics, middle class orientation of treatment, language barriers, maintenance of traditional forms of psychotherapy, culture-bound diagnosis and treatment, and discrimination in service delivery (Karno, 1966; Burruel and Chavez, 1974; Torrey, 1972; Padilla and Ruiz, 1973). Geographic location of the clinic within the Mexican American community and employment of bilingual and bicultural staff are widely recognized as basic requirements for provision of mental health services to the Mexican American population. In a study of Mexican Americans where both of these fundamental requirements are fulfilled in two of the three communities sampled, those respondents who have had contact with mental health facilities find the staff easy to talk to and believe the treatment of clients is usually successful (Keefe et al., in press). Moreover, the majority of respondents as a whole say they would be willing to use a mental health clinic. We might conclude that while culture- and class-bound treatment may affect a Mexican American client's continuation of treatment and the treatment's clinical success, it appears to have little bearing on the initial decision to use mental health services.

Language and cultural beliefs and attitudes are frequently suggested to account for Mexican Americans' limited utilization of mental health clinics. Language, in this case, is important not only because it is basic to the communication between clients and staff but because it is intimately tied to perception and social behavior. Edgerton and Karno (1971) have demonstrated a relationship between language usage and attitudes toward mental illness among Mexican Americans. Newton (1977) finds Mexican Americans in general

have a coherent belief system associated with perception of mental and emotional problems and their treatment. According to the model he presents, psychiatric help is sought only after recourse to other helping agents and when the problem is so serious that loss of mental control is imminent. Thus it is possible that Mexican Americans put off seeking professional care longer than Anglos might. Fabrega, Swartz, and Wallace's (1968) research indicating the greater disorganization and regression of Mexican American schizophrenics compared to Anglo American and Negro American schizophrenics tends to corroborate this viewpoint.

Cultural attitudes towards Anglo institutions in general are often suggested as inhibiting use of mental health services (Burruel et al., 1974; Padilla et al., 1973; Torrey, 1972). Mexican Americans are believed to consider majority group institutions as alien and hostile, staffed by Anglos who are regarded as cold and impersonal. While Anglos may also perceive agencies as cold and hostile, at least one researcher contends that they are nevertheless more likely to seek treatment from such agencies (Torrey, 1972). As indicated above, Keefe et al. (in press) find no strong evidence of negative attitudes toward mental health services among either Anglos or Mexican Americans in general. Furthermore, while both ethnic groups claim to be willing to use a mental health clinic, neither group has a very high rate of utilization.

Presence of folk medical beliefs and the associated folk curing system of specialists are perhaps the most controversial, certainly the most distinctly "Mexican American," explanation proposed for underutilization. Early studies attribute much of the differences between Anglo and Mexican Americans' health behavior to the latter's folk medical beliefs and preference for folk specialists such as curanderos (folk curers), sobadores (masseurs), parteras (midwives), and so on (Clark, 1959; Saunders, 1954;

Schulman, 1960). A few studies specifically mention curanderismo as a Mexican American alternative to conventional psychotherapy in response to emotional problems (Kiev, 1968; Madsen, 1964; Senter, 1947). The extent of belief in and use of the folk medical system by Mexican Americans today is a cloudy issue. Madsen (1964) points out that folk medicine is primarily confined to lower class Mexican Americans. He goes on to say, however, that the middle class retains some belief in supernatural causation and that even members of the upper class sometimes rely on curanderos. A survey of 75 women in an urban housing development in the Southwest disclosed almost universal belief in folk illnesses and the use of curanderos by one out of five respondents (Martinez and Martin, 1966). Granger (1976) and Graham (1976) both assert that folk medical beliefs and the use of curanderos are present throughout the Mexican American community, among rich and poor, the college-educated and those with less schooling. Empirical research based on large samples of urban Mexican Americans, on the other hand, indicates there is no pervasive use of folk curers (Edgerton et al., 1970; Keefe et al., in press, 1977).

While some researchers postulate that the folk medical system and modern scientific medicine are mutually exclusive to the extent that involvement in one precludes use of the other (thus explaining low clinic use), evidence exists to the contrary. Weaver's (1970) work in New Mexico leads him to propose a single model of Mexican American illness referral which includes both folk specialists amd medical doctors. In a study of 25 Mexican American patients at the Pediatric and Psychiatric Outpatient Clinics of a teaching hospital, Creson et al. (1969) found that 20 had a good knowledge of folk medicine and 12 were members of families who had used folk curers. Nall et al.'s (1967) study of 27 Mexican Americans undergoing treatment for

tuberculosis and 26 others who had rejected treatment indicates there is no relationship between commitment to folk medical beliefs or the use of folk healers and the acceptance of modern medical regimes. Both Torrey (1972) and Kay (1972) conclude that folk medicine coexists with modern scientific medicine in the Mexican American community--the utilization of one or the other being affected by numerous factors including illness symptoms and self-diagnosis, the degree of belief in the folk medical system, the influence of friends and relatives, the accessibility of healing specialists, the success of the first-choice specialist's treatment, and so on.

Given these various reasons proposed to account for low mental health clinic utilization we can hypothesize which characteristics might typify Mexican Americans who come in contact with mental health services as opposed to those Mexican Americans who have not made contact. We might expect the Mexican Americans with clinic contact to: (1) be of relatively high socio-economic status, (2) have a more limited extended family, (3) rely on friends as well as family for emotional problems, (4) consult less with doctors, clergymen, and Mexican American community workers for help with emotional problems, (5) be more acculturated, (6) be English-speaking, (7) consult more frequently with other professional psychiatric sources of help for emotional problems, and (8) lack a commitment to the folk medical system. We might also expect those Mexican Americans who have not had contact with a mental health clinic to hold an unfavorable attitude toward mental health services. Using data from a large random sample of Mexican Americans, we can set about testing the explanatory power of each of these factors.

II. Description of the Sample

A survey of Mexican Americans was conducted in three Southern California

cities in the spring and summer of 1975. The smallest of the three towns has a population of over 18,000 and the other two both have over 70,000 residents. The Mexican American population density in the three cities ranges from 20% to 40%. Three census tracts representing areas of relatively high, medium, and low ethnic density were chosen in each community for random sampling. Interviews with 666 Spanish-surnamed individuals, contacted door-to-door by bilingual interviewers of Mexican descent, were completed.[2] About an equal number of Spanish and English questionnaires were administered.

Three quarters of the respondents are women, and the majority are married, averaging 42 years of age. Most are also of low socio-economic status; only 15% of the sample reside in white collar households and the average respondent has just nine years of education.

There is considerable cultural variation within the sample of Mexican Americans. Forty percent of the respondents are first generation (born in Mexico); 35% are second generation (born in the United States with one or both parents born in Mexico); and 19% are third generation (born in the United States with both parents born in the United States).[3] With regard to language, 42% speak mainly Spanish, 27% are bilingual, and 31% speak primarily English. Ethnic identity is also fairly diverse. While the majority of respondents identify as "Mexican," 27% identify as "Mexican American," 7% prefer "American of Mexican descent," and 6% are "Chicano." Generational differences are apparent with respect to these cultural indices. Typically, first generation respondents speak mainly Spanish and identify as "Mexican;" second generation respondents speak English and probably also Spanish and identify as either "Mexican" or "Mexican American;" and the third generation speaks mainly English and prefers to identify as something other than "Mexican."[4]

Of the 666 respondents, only 2% had used the local mental health clinic

in the last two years. In order to have a fairly large sample for comparative purposes, therefore, respondents were considered to have been in touch with mental health services if they or anyone in their household had ever been in contact with or used a mental health clinic. Generally, this meant that the respondent had used a clinic at one time or that the respondent had accompanied a household member (frequently a child) to a clinic. A total of 63 respondents (10% of the sample) are thus considered to have had contact with mental health services.

III. Curanderismo and Emotional Problems

Before turning to the general comparison of Mexican Americans with and without mental health service contact, let us analyze in some detail the belief in folk curing among respondents and its relationship to the use of modern psychiatric services. There is no evidence in the data that curanderos are an important part of the urban Mexican American emotional support system. When given a hypothetical situation wherein a woman believes she is bewitched, only 17% of the respondents recommend that she go to a curandero for help. Curanderos are never mentioned as the first place to go for help when someone has an emotional problem and are suggested by just five of all respondents as the second or third source one should consult. Use of curanderos by respondents themselves is extremely low -- 2% report seeing a curandero in the last year for an emotional problem. In interviews conducted a year later, only 7% of the respondents say they have ever gone to a curandero for any type of problem (Keefe et al., 1977). In sum, there appears to be no widespread reliance by urban Mexican Americans on folk healers.

The effect of economic and cultural factors on the distribution

of folk medical beliefs can be determined by a comparison of respondents who have a commitment to folk curing with those who do not. Respondents who recommend a curandero to help a woman who believes she is bewitched or who have seen a curandero themselves for an emotional problem in the last year (N=95) are considered to have a strong commitment to the efficacy of folk curing. An examination of the intra-ethnic distribution of these respondents indicates several things. First, it is clear that no economic or cultural sub-group has a very strong tendency to invoke curanderismo (see Table 1). No more than one out of four Mexican Americans, regardless of their background, is committed to the folk healing system. At the same time, the distribution of belief in curanderismo cuts across all economic and cultural sub-groups -- including some respondents who are third generation, primarily English-speaking, college-educated, and who are from white collar households. Nevertheless, those most committed to folk healing are the recent Mexican immigrants who came to the United States after the age of fifteen, other respondents with traditional cultural characteristics such as Spanish language usage, a "Mexican" ethnic identity, and Catholic religious affiliation, and respondents in the lowest socio-economic stratum (see Table 2).[5]

Finally, we must consider the relationship between belief in folk curing and the use of mental health professionals. Respondents were asked if they had ever gone to a private counselor, psychologist, or psychiatrist, if they had used the local mental health clinic in the last two years, and if they or any member of their household had ever been in contact with a mental health clinic. As can be seen in Table 3, there is no significant difference in the use of professional psychiatric

care between respondents who do or do not believe in curanderismo. In other words, belief in the folk curing system appears to have no bearing on the decision to seek professional mental health services.

IV. Comparison of Respondents with and without Mental Health Clinic Contact

Having rejected the possibility that the folk medical system is responsible for Mexican Americans' underutilization of mental health facilities, we can now consider the other reasons that have been proposed. As can be seen in Table 4, very few factors appear to be correlated with mental health clinic contact. The two indicators of socio-economic status, education and occupation, appear to be unrelated to clinic usage. There is no evidence that Mexican Americans of relatively high SES are more likely to make use of mental health facilities. Nor do we find any support for Nall and Speilberg's (1967) contention that integration into the ethnic sub-community determines acceptance of modern health treatment. Taking into consideration four measures of extended family integration, none are significantly related to contact with a mental health clinic; respondents who have contacted a clinic are just as likely to have strong extended families as respondents who have made no contact.

More important in explaining mental health clinic use among Mexican Americans are two variables reflecting general social disorganization: marital status and the female-headed household. Respondents who contact clinics are more likely to be single/separated/divorced/widowed and live in a female headed household. These factors are known to be highly correlated with mental health service utilization in the

general population. In fact, Tischler, Henisz, Myers, and Boswell (1975) find they are more significant predictors of utilization than ethnicity and social class. Given the higher incidence of marital instability and female-headed households among Mexican Americans in comparison to Anglos (Uhlenberg, 1972), therefore, we should expect greater mental health clinic use by the ethnic minority. Substantial evidence to the contrary implies that other factors are important mediators in the decision by Mexican Americans to use a mental health facility.

Only one of the cultural indicators, language usage, has a significant correlation coefficient leading us to conclude that level of acculturation in general is not associated very strongly with mental health clinic contact. Respondents who are first generation, Catholic, or who identify as "Mexican" are just as likely to make contact as respondents who are third generation, Protestant, or who identify as "American of Mexican descent." The greater likelihood that English-speakers will contact mental health clinics could be interpreted in other ways aside from the possibility that these respondents are more acculturated and therefore more amenable to the treatment offered at clinics. It may be merely a reflection of the language limitations of the clinic personnel. It could also be the result of the English-speakers' greater awareness about the services available. For example, 57% of the respondents who speak mainly English know where their neighborhood mental health clinic is located compared to 39% of the Spanish-speaking respondents.

At this point, it should be reiterated that there is no indication that attitudes toward mental health services might be responsible for clinic underutilization by Mexican Americans. Respondents who have not had contact with a clinic express a willingness to use one nevertheless. In fact, these Mexican Americans are more willing to go to a clinic than Anglos (58% vs. 44%). Respondents who have had some contact with a mental health facility or know a friend or relative who has (N=90) find the staff easy to talk to (90%) and believe the clinics are successful in their treatment of clients (88%). These opinions are also held by two-thirds or more of the sub-sample of Mexican Americans (N=16) who have used a mental health clinic in the last two years (Keefe et al., in press). In short, there is no evidence that Mexican Americans on the whole or clinic users in particular have negative attitudes toward mental health services. If anything, the Mexican Americans show slightly more approval of local mental health services than do Anglos.

Returning to Table 4, it appears that five of the alternative sources of emotional support are unrelated to clinic contact, including relatives, doctors, clergymen, Mexican American community workers, and curanderos. Respondents who have as well as respondents who have not contacted a mental health clinic utilize these resources about equally. The tendency to consult with friends, on the other hand, appears to be more characteristic of respondents who contact clinics. Far more important, and clearly the most highly correlated of all variables, is the tendency to seek help from a private counselor, psychologist, or psychiatrist.

The greater reliance by Mexican Americans who have contacted a clinic on both friends and private therapists is notable. Reliance on these two resources has been found to be much more typical of Anglos than Mexican Americans (Keefe et al., 1977). Yet we find the frequency with which Mexican American clinic users and Anglos in general consult with friends (38% v.s. 34%) and private therapists (19% v.s. 21%) is very similar. We might conclude that Mexican Americans who seek professional mental health care are less likely to adhere to the cultural value of solving problems primarily within the family.

The greater use of private therapists has implications with regard to the perception of mental illness and its treatment. As we mentioned earlier, Mexican Americans in general believe professional psychiatric help should be sought only after all other alternatives fail and mental control is in danger of being lost (Newton, 1977). The extremely high use of private therapists (19% v.s. 2%), as well as use of public mental health services, by the Mexican American clinic users in contrast to other Mexican Americans might indicate either: (1) that the users have a different perception of the proper treatment for emotional problems or (2) that the users are generally those Mexican Americans who have met the conditions believed to be necessary for seeking professional therapy, i.e. they have fairly serious problems which have not responded to other sources of help. Considering the fact that Newton (1977) found little variation between clinic users and non-users with regard to perception of mental health care, the latter explanation seems most appropriate. In any case, both interpretations lead us to conclude that ethnic differerences in the perception of mental

disorders and their treatment are important in explaining the underutilization of mental health services by Mexican Americans.

V. Summary

From the preceding discussion, we can conclude that there is no significant relationship between contact with mental health clinics by Mexican Americans and: SES; the presence of an integrated extended family; the reliance on relatives, doctors, clergymen, Mexican American community workers, or curanderos for emotional support; commitment to the folk medical system; or attitudes toward mental health services. Mexican American respondents who contact clinics and those who do not are equally likely to be of low socio-economic status, have a fairly strong local extended family, and express little belief in or use of folk healers. Moreover, both rely on most non-professional sources of emotional support to the same extent and both have generally favorable attitudes toward mental health services.

In addition, the significant correlations of two other factors (marital status and the female-headed household), while important in determining the likelihood of clinic use within the ethnic population, are of little help in explaining the difference in utilization rates between ethnic groups. With greater marital instability and a greater number of female-headed households, Mexican Americans might be expected to use mental health clinics more often than Anglos rather than less often.

In light of the fact that only one cultural indicator correlates significantly with use of mental health clinics, it appears that

acculturation level per se is relatively unimportant in explaining the underutilization by Mexican Americans. Instead, the greater use of clinics by English-speakers is probably the result of their greater awareness of mental health services and the limited number of Spanish-speaking personnel available at mental health facilities.

The tendency for Mexican Americans who contact mental health clinics to consult often with friends as well as relatives indicates a somewhat different approach to handling emotional problems compared to other Mexican Americans. Whereas Mexican Americans in general prefer to confine their discussion of emotional problems within the family, the Mexican American clinic users, like Anglos, talk about their problems with friends and relatives alike. The factors responsible for this difference in dealing with emotional problems are elusive and require further study. Perhaps because of the gravity of their problems and the inability to find help among relatives alone, the Mexican American clinic users out of necessity turn to friends for additional help.

The high correlation between use of private psychiatric help and use of public mental health clinics leads us to believe that perceptions of mental illness and its treatment are key to understanding clinic underutilization by Mexican Americans. Professional therapy is not commonly sought by Mexican Americans because it is considered a sign of personal weakness (Newton, 1977). Every effort is made to handle emotional problems without recourse to psychiatric care. And only when emotional problems become "mental" (i.e. extremely serious involving an inability to cope, a loss of control, and a loss of contact with

reality) is professional mental health care considered essential. The Mexican Americans who use mental health clinics, therefore, are probably those individuals who recognize they have serious problems which require professional therapy and who have sought private as well as public psychiatric help as a consequence.

The decision to undergo professional therapy is an important one regardless of ethnicity. It is suggested here that the main reason Mexican Americans underutilize mental health services and, indeed, professional psychiatric care in general involves their perception of mental illness and its treatment. Concomitantly, because Anglos believe problems require professional therapy at an earlier stage, they in turn use mental health facilities at a greater rate. In any event, any future research should take into consideration the potential for ethnic differences in perception of mental illness and related rates of mental health service utilization.

FOOTNOTES

1. Both Jaco (1957, 1960) and Madsen (1969) conclude from their studies that Mexican Americans have lower rates of mental illness *per se* because of their strong extended family networks, but considering the absence of evidence for a direct causal relationship, this conclusion can only be speculative. Cross-cultural research with exacting methods and sampling would be required in order to demonstrate a lower rate of mental illness among Mexican Americans.

2. Support for this study by the National Institute of Mental Health, Grant number MH26099, Center for Minority Group Mental Health Programs, is greatefully acknowledged.

3. The birthplace of one or both parents of the respondent could not be determined for 6% of the sample.

4. More detailed description of the sample can be found in Keefe *et al.*, in press.

5. Age, sex, and *barrio* neighborhood residence are not significantly correlated with commitment to *curanderismo*.

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Table 1
Relationship Between Economic and Cultural Variables
and Commitment to Curanderismo by Percentage

Variable	Commitment Present	Commitment Absent	Total %
I. Economic			
Education			
≤8 years	23	77	100
9-11 years	11	89	100
12 years	11	89	100
College	9	91	100
Occupation			
Operative-laborer	19	81	100
Skilled	13	87	100
Clerical-Sales	13	87	100
Business-Professional	4	96	100
II. Cultural			
Generation			
First	23	77	100
Second	13	87	100
Third	11	89	100
First generation age at immigration			
≤ 15 years of age	11	89	100
≥ 16 years of age	26	74	100
First generation number of years in U.S.			
1-5 years	26	74	100
6-10 years	27	73	100
11-15 years	28	72	100
16-20 years	19	81	100
≥ 21 years	13	87	100
Language			
Mainly Spanish	23	77	100
Bilingual	12	88	100
Mainly English	11	89	100
Ethnic identity			
"Mexican"	19	81	100
"Chicano"	22	78	100
"Mexican American"	13	87	100
"American of Mexican descent"	8	92	100
Religion			
Catholic	17	83	100
Protestant	7	93	100
Agnostic	18	82	100

Table 2

Pearson Correlation Coefficients for Relationship Between Economic and Cultural Variables and Commitment to Curanderismo*

Variable	r	P
I. Economic		
Years of Education	-.13	.001
Occupation Level (Duncan's SEI)	-.12	<.01
II. Cultural		
First generation	.11	<.01
Immigration after 15 years of age	.17	<.01
Immigrant's years of residence in U.S.	-.16	.01
Spanish language	.16	.001
"Mexican" ethnic identity	.08	<.05
Catholic religion	.08	<.05
Protestant religion	-.09	.02

*Variables for the Pearson correlation coefficients are either interval level or dichotomous.

Table 3

Relationship Between Use of Professional Psychiatric Care and Commitment to Curanderismo

Professional Psychiatric Help	Commitment Present (N=95)	Commitment Absent (N=571)	Chi Square	P
Respondent ever contacted private therapist	5%	3%	<1	NS
Respondent's household ever contacted mental health clinic	10%	9%	<1	NS
Respondent used mental health clinic in last 2 years	3%	2%	<1	NS

Table 4

Pearson Correlation Coefficients for Relationship Between Socio-economic, Cultural, and Emotional Support System Variables and Contact with a Mental Health Clinic*

Variable	r	P
I. Social and Economic		
Years of education		NS
Occupation level (Duncan's SEI)		NS
Unmarried	.12	.001
Female-headed household	.09	<.02
II. Extended family		
Relatives in town		NS
Number of relatives in town		NS
Number of kin visited weekly		NS
Number of instances of mutual aid		NS
III. Cultural		
Generation		NS
English language	.08	<.05
Ethnic identity		NS
Religious affiliation		NS
IV. Sources of emotional support		
Relative/compadre		NS
Friend	.09	<.02
Doctor		NS
Clergyman		NS
Community worker		NS
Curandero		NS
Private therapist	.26	.001

*Variables for the Pearson correlation coefficients are either interval level or dichotomous.